

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11877-63-045881

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED DEC 5 1963

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

St. Louis

Length of stay in 1b
7 days

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Alexian Brothers

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Madison

c. CITY OR TOWN Fredericktown

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

First Owen

Middle

Last Parson

4. DATE OF DEATH

Month 11

Day 29

Year 63

5. SEX Male

6. COLOR OR RACE White

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday) 78

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Gen. Farming

11. BIRTHPLACE (City and state or country)

West Plains Mo

12. CITIZEN OF WHAT COUNTRY

U.S.A

13a. FATHER'S NAME

William Parson

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Lola A

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date)

No

16. SOCIAL SECURITY NO.

M

17. INFORMANT

Morris Parson

Address

St Louis Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1) Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH
2 wks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

2) Atherosclerosis of Heart Arteries

3 yrs.

DUE TO (c)

3) Cardiac Failure

1 wk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Belated Pneumonia - 1 wk.

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
4221

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11/21/63 to 11/29/63 and last saw her alive on 11/29/63
Death occurred at 1 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

12/2/63

23c. NAME OF CEMETERY OR CREMATORY

MARCUS MEMORIAL

23d. LOCATION (City, town, or county)

FREDERICKTOWN

(State)

Mo

24. FUNERAL DIRECTOR

ADDRESS

Wilson

Fredericktown, Mo.

25. DATE RECD. BY LOCAL REG.

DEC 2

26. REGISTRAR'S SIGNATURE

Paul Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Frank Proff

Licensed Embalmer No. 4356

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.